A variety of treatment modalities are available to treat varicose veins/venous insufficiency, including surgical approaches, thermal ablation, and sclerotherapy. The application of each of these treatment options is influenced by the severity of the symptoms, type of vein, source of venous reflux, and the use of other (prior or concurrent) treatments.

The venous system of the lower extremities consists of the superficial veins (this includes the great and small saphenous and accessory, or duplicate veins that travel in parallel with the great and small saphenous veins), the deep system (popliteal and femoral veins), and perforator veins that cross through the fascia and connect the deep and superficial systems. One-way valves are present within all veins to direct the return of blood up the lower limb. Since venous pressure in the deep system is generally greater than that of the superficial system, valve incompetence at any level may lead to backflow (venous reflux) with pooling of blood in superficial veins. Varicose veins with visible varicosities may be the only sign of venous reflux, although itching, heaviness, tension, and pain may also occur. Chronic venous insufficiency secondary to venous reflux can lead to thrombophlebitis, leg ulcerations, and hemorrhage. The CEAP classification considers the clinical, etiologic, anatomic, and pathologic (CEAP) characteristics of venous insufficiency, ranging from class 0 (no visible sign of disease) to class 6 (active ulceration).

Treatment of venous reflux/venous insufficiency is aimed at reducing abnormal pressure transmission from the deep to the superficial veins. Conservative medical treatment consists of elevation of the extremities, graded compression, and wound care when indicated. Conventional surgical treatment consists of identifying and correcting the site of reflux by ligation of the incompetent junction followed by stripping of the vein to redirect venous flow through veins with intact valves. While most venous reflux is secondary to incompetent valves at the saphenofemoral or saphenopopliteal junctions, reflux may also occur at incompetent valves in the perforator veins or in the deep venous system. The competence of any single valve is not static and may be pressure dependent. For example, accessory saphenous veins may have independent saphenofemoral or saphenopopliteal junctions that become incompetent when the great or small saphenous veins are eliminated and blood flow is diverted through the accessory veins.
Policy

Coding Information
Click the links below for attachments, coding tables & instructions.
Attachment I - CPT® Code List & Instructions

When a service may be considered medically necessary/not medically necessary or investigational.

Great or Small Saphenous Veins
Treatment of the great or small saphenous veins by surgery (ligation and stripping), endovenous radiofrequency or laser ablation, or microfoam sclerotherapy may be considered medically necessary for symptomatic varicose veins/venous insufficiency when the following criteria have been met:

There is demonstrated saphenous reflux and CEAP [Clinical, Etiology, Anatomy, Pathophysiology] class C2 or greater; AND documentation of one or more of the following indications:

- Ulceration secondary to venous stasis; OR
- Recurrent superficial thrombophlebitis OR
- Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; OR
- Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, AND the symptoms significantly interfere with activities of daily living, AND conservative management including compression therapy for at least 3 months has not improved the symptoms.

Treatment of great or small saphenous veins by surgery, endovenous radiofrequency or laser ablation, or microfoam sclerotherapy that do not meet the criteria described above is considered cosmetic and therefore a benefit exclusion.

Accessory Saphenous Veins
Treatment of accessory saphenous veins by surgery (ligation and stripping) or endovenous radiofrequency or laser ablation may be considered medically necessary for symptomatic varicose veins/venous insufficiency when the following criteria have been met:

Incompetence of the accessory saphenous vein is isolated, OR the great or small saphenous veins had been previously eliminated (at least 3 months); AND

There is demonstrated accessory saphenous reflux; AND

There is documentation of one or more of the following indications:
- Ulceration secondary to venous stasis; OR
- Recurrent superficial thrombophlebitis; OR
- Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; OR
- Persistent pain, swelling, itching, burning, or other symptoms are associated with
saphenous reflux, AND the symptoms significantly interfere with activities of daily
living, AND conservative management including compression therapy for at least 3
months has not improved the symptoms.

Treatment of accessory saphenous veins by surgery, endovenous radiofrequency or laser
ablation, microfoam sclerotherapy, that do not meet the criteria described above is
considered cosmetic and therefore a benefit exclusion.

**Symptomatic Varicose Tributaries**
The following treatments are considered medically necessary as a component of the
treatment of symptomatic varicose tributaries when performed either at the same time or
following prior treatment (surgical, radiofrequency or laser) of the saphenous veins (none of
these techniques has been shown to be superior to another):

- Stab avulsion
- Hook phlebectomy
- Sclerotherapy
- Transilluminated powered phlebectomy

Treatment of symptomatic varicose tributaries when performed either at the same time or
following prior treatment of saphenous veins using any other techniques than noted above
is considered investigational.

**Perforator Veins**
Surgical ligation (including subfascial endoscopic perforator surgery) or endovenous
radiofrequency or laser ablation of incompetent perforator veins may be considered
medically necessary as a treatment of leg ulcers associated with chronic venous
insufficiency when the following conditions have been met:

- There is demonstrated perforator reflux; AND
- The superficial saphenous veins (great, small, or accessory saphenous and
  symptomatic varicose tributaries) have been previously eliminated; AND
- Ulcers have not resolved following combined superficial vein treatment and
  compression therapy for at least 3 months; AND
- The venous insufficiency is not secondary to deep venous thromboembolism.

Ligation or ablation of incompetent perforator veins performed concurrently with
superficial venous surgery is not medically necessary.

**Telangiectasias, and Reticular Veins, and other CEAP Category 1 veins**
Treatment of reticular veins, or telangiectasia such as spider veins, angiomata, and
hemangiomata is considered cosmetic and therefore a benefit exclusion.

**Other Veins**
Techniques for conditions not specifically listed above are investigational, including, but
not limited to:

- Sclerotherapy techniques, other than microfoam sclerotherapy, of great, small, or
  accessory saphenous veins
• Sclerotherapy of perforator veins
• Sclerotherapy of isolated tributary veins without prior or concurrent treatment of saphenous veins
• Stab avulsion, hook phlebectomy, or transilluminated powered phlebectomy of perforator, great or small saphenous, or accessory saphenous veins
• Endovenous radiofrequency or laser ablation of tributary veins
• Endovenous cryoablation of any vein
• Mechanochemical ablation of any vein
• Cyanoacrylate adhesive of any vein

The use of cyanoacrylate adhesive for permanent closure of lower extremity superficial truncal veins, such as the great saphenous vein (GSV), through endovascular embolization with coaptation is considered not medically necessary.

Policy Guidelines

The standard classification of venous disease is the CEAP (Clinical, Etiologic, Anatomic, Pathophysiologic) classification system. The following is the Clinical portion of the CEAP.

Clinical Classification
C0 No visible or palpable signs of venous disease
C1 Telangiectasies or reticular veins
C2 Varicose veins
C3 Edema
C4a Pigmentation and eczema
C4b Lipodermatosclerosis and atrophie blanche
C5 Healed venous ulcer
C6 Active venous ulcer
S Symptoms including ache, pain, tightness, skin irritation, heaviness, muscle cramps, as well as other complaints attributable to venous dysfunction
A Asymptomatic

The Etiologic, Anatomic, and Pathophysiologic portions of the classifications are online (http://www.veinforum.org/uploadDocs/1/Revised-CEAP-Classification---May-2004.pdf).

It should be noted that the bulk of the literature discussing the role of ultrasound guidance refers to sclerotherapy of the saphenous vein, as opposed to the varicose tributaries. When ultrasound guidance is used to guide sclerotherapy of the varicose tributaries, it would be considered either not medically necessary or incidental to the injection procedure.

There is no specific CPT® code for transilluminated powered phlebectomy. Providers might elect to use CPT® codes describing stab phlebectomy (37765 or 37766) or unlisted vascular surgery procedure (37799).

Mechanochemical ablation should be reported with the unlisted vascular surgery procedure code 37799.

There is no specific CPT® for microfoam sclerotherapy. Providers might elect to use CPT® codes describing sclerotherapy (36468-36471) or the unlisted vascular surgery procedure code.
37799. Use of codes 36475-36476 would be inappropriate as the procedure is not ablation therapy.

Reference Resources

15. van der Velden SK, Biemans AA, De Maeseneer MG, et al. Five-year results of a randomized clinical trial of conventional surgery, endovenous laser ablation and
19. Todd KL, 3rd, Wright D, for the Vanish-Investigator Group. The VANISH-2 study: a randomized, blinded, multicenter study to evaluate the efficacy and safety of polidocanol endovenous microfoam 0.5% and 1.0% compared with placebo for the treatment of sapheno-femoral junction incompetence. Phlebology. Oct 2014; 29 (9):608-618. PMID 23864535

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer’s benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member’s contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.
Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member’s health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member’s benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Coverage varies according to the member’s group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member’s employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>03/2014</td>
<td>ICD 10 remediation. Revised /updated standard language (document precedence and audit information sections) added. Code tables reformatted. Hyperlinks created for attachments. ICD diagnosis list hyperlink also created for URL for website.</td>
</tr>
<tr>
<td>03/2015</td>
<td>Local expert input and changes to be c/w BCBSA policy- eliminates prior requirement for treating saphenous vein if no reflux is identified for accessory, tributary and perforators.</td>
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<tr>
<td>10/2016</td>
<td>Adopted BCBSA MPRM 7.01.124, Updated coding table ICD 10 Section.</td>
</tr>
<tr>
<td>10/2017</td>
<td>Policy updated with literature review; references added, CPT® Codes 37473, 37474 &amp; 37243 added to coding table Policy statements remain unchanged.</td>
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<tr>
<td>11/2017</td>
<td>Added codes effective 01/01/2018 36465 &amp;36466 to require prior authorization.</td>
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<tr>
<td>07/2018</td>
<td>Policy reviewed, aligned with MPRM 7.01.124 added language The use of cyanoacrylate adhesive for permanent closure of lower extremity superficial truncal veins, such as the great saphenous vein (GSV), through endovascular embolization with coaptation is considered not medically necessary.</td>
</tr>
<tr>
<td>11/2018</td>
<td>Policy clarified as to the definition of CEAP Category 1 veins. Removed ICD-10-CM table.</td>
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</table>
Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors  Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Kate McIntosh, MD, FAAP
Senior Medical Director

Attachment I
CPT® Code List & Instructions

<table>
<thead>
<tr>
<th>Code</th>
<th>Number</th>
<th>Description</th>
<th>Policy Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>The following codes will be considered as medically necessary when applicable criteria have been met.</td>
<td></td>
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<tr>
<td>CPT®</td>
<td>36465</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36466</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36468</td>
<td>Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36470</td>
<td>Injection of sclerosing solution; single vein</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36471</td>
<td>Injection of sclerosing solution; multiple veins, same leg</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36473</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>Code</td>
<td>Number</td>
<td>Description</td>
<td>Policy Instructions</td>
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<tr>
<td>CPT®</td>
<td>36474</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanoochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>36475</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>36476</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>36478</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>36479</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>37243</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>37500</td>
<td>Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37700</td>
<td>Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37718</td>
<td>Ligation, division, and stripping, short saphenous vein</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37722</td>
<td>Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below</td>
<td>Prior approval required</td>
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<tr>
<td>Code</td>
<td>Number</td>
<td>Description</td>
<td>Policy Instructions</td>
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<tr>
<td>CPT®</td>
<td>37735</td>
<td>Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37760</td>
<td>Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37761</td>
<td>Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37765</td>
<td>Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37766</td>
<td>Stab phlebectomy of varicose veins, one extremity; more than 20 incisions</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>CPT®</td>
<td>37780</td>
<td>Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>37785</td>
<td>Ligation, division, and/or excision of varicose vein cluster(s), 1 leg</td>
<td>Prior approval required</td>
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<tr>
<td>CPT®</td>
<td>37799</td>
<td>Unlisted procedure, vascular surgery</td>
<td>Prior approval required</td>
</tr>
<tr>
<td>HCPCS</td>
<td>S2202</td>
<td>Echosclerotherapy</td>
<td>Prior approval required</td>
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